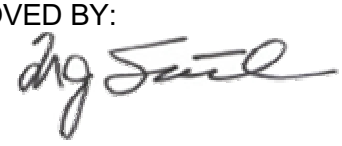
DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
ASSISTING CLIENTS IN APPLYING FOR PATIENT ASSISTANCE PROGRAMS (PAPs)	**103.6**	**08/15/04**	**1 of 3**
APPROVED BY:  Director	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) **1**

INTRODUCTION

1.1 The Department of Mental Health (DMH) has implemented an Indigent Medications Project (IMP) in order to assist indigent and low income clients to obtain needed medications at no cost to themselves or to DMH.

1.2 IMP is designed to make systemwide use of Patient Assistance Programs (PAPs) that have been established by the pharmaceutical industry for individuals who cannot pay for the medications they need.

1.3 IMP is a component of the DMH benefits establishment process; clients identified as eligible for PAPs are also eligible for assistance with benefits establishment.

PURPOSE

2.1 To ensure that DMH staff identify indigent and low income clients who do not have the benefits they need to pay for their medications.

2.2 To ensure that DMH staff assist indigent and low income clients to apply for the PAPs made available by the pharmaceutical industry.

2.3 To ensure that replacement medications supplied by PAPs are appropriately monitored and dispensed.

2.4 To ensure benefits establishment assistance to clients who are enrolled in PAPs.

POLICY

3.1 Indigent and low income clients in need of psychotropic medications shall, to the extent possible, be provided medication at low or no cost through any source available. Clients eligible for PAPs are those who have no prescription coverage and, thus, cannot pay for needed medications.

PROCEDURE

4.1 Clinic managers shall develop and implement internal procedures to identify and assist indigent clients to apply for PAPs.

4.1.1 Each month, clinic managers shall access the list of prescriptions written for indigent clients served by his/her clinic and make the list available to all staff in order to identify clients who can be assisted to apply for PAPs. (Indigent Client List – HMHPR 934 Report)

4.1.2 Psychiatrists shall select clients from the Indigent Client List who are clinically appropriate for PAPs.

4.1.3 DMH staff shall assist new clients to apply for PAPs who are identified at intake as indigent and assessed by the psychiatrist to be clinically appropriate.

4.1.4 DMH staff shall assist clients who are eligible for PAPs with the establishment of benefits to which they are entitled, e.g., Medi-Cal, Social Security, etc.

<u>DMH Pharmacy Services/IMP Coordinator</u>

4.2 DMH Pharmacy Services and the Indigent Medications Project Coordinator shall monitor replacement medications sent by the pharmaceutical companies.

4.2.1 Replacement medications sent by pharmaceutical companies shall be logged into a database managed by the IMP Coordinator.

4.2.2 Replacement medications shall be stored according to the standards set forth in DMH Policy #103.2 "Storing, Administering, and Accountability of Medications."

4.2.3 Logged replacement medications shall be sent by DMH Pharmacy Services to the appropriate dispensing pharmacies in a timely manner.

4.2.4 The Indigent Medications Project Coordinator shall prepare a monthly cost savings report for the Leadership Team, District Chiefs, and Clinic Managers.

4.3 All pharmacies that have contracts with DMH shall participate in the Indigent Medications Project.

<u>DMH Staff</u>

4.4 DMH staff shall assist indigent clients to complete the PAP applications. An explanation of the purpose of the application shall be given to the client at the time of application.

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4.5 The client shall verbalize an understanding of the PAP and shall sign the application(s) certifying that the information is true.

4.6 The client shall authorize the disclosure of his/her protected health information (PHI) (Attachment I) based on the standards set forth in DMH Policy #500.2, "Use and Disclosure of Protected Health Information Requiring Authorization."

4.7 The "DMH Fax Cover for Transmitting PHI" (Attachment II) shall be used when faxing PAP applications and reports based on standards set forth in DMH Policy #500.21, "Safeguards for Protected Health Information."

4.8 The DMH "Account Tracking Sheet: (Attachment III) shall be completed and kept in the client's medical record based on standards set forth in DMH Policy #500.6, "Accounting of Disclosures of Protected Health Information."

4.9 Each clinic shall keep copies of PAP applications in the clients' medical record and/or in a central location accessible upon audit.

4.10 Copies of PAP applications shall also be kept in the DMH Pharmacy Services office for a period of six (6) months.

ATTACHMENT

Attachment I	Authorization for Request for Use and Disclosure of Protected Health Information
Attachment II	DMH Fax Cover for Transmitting PHI
Attachment III	Account Tracking Sheet

REFERENCES

DMH Policy #103.2	Storing, Administering, and Accountability of Medications
DMH Policy #500.2	Use and Disclosure of Protected Health Information Requiring Authorization
DMH Policy #500.21	Safeguards for Protected Health Information
DMH Policy #500.6	Accounting of Disclosures of Protected Health Information

REVIEW DATE

This policy shall be reviewed on or before August 1, 2009.

DEPARTMENT OF MENTAL HEALTH

DMH FAX COVER FOR TRANSMITTING PHI

FAX DETAILS

Date Transmitted: _____ Time Transmitted: _____

Number of Pages (including cover sheet): _____

Intended Recipient: _____

TO	FROM
Name: _____	Name: _____
Facility: _____	Facility: _____
Address: _____	Address: _____
Telephone #: _____	Telephone #: _____
Fax #: _____	Fax #: _____

Documents being faxed:

- ☐ Clinical Records
- ☒ Other: PATIENT ASSISTANCE PROGRAM APPLICATION(S)

CONFIDENTIALITY STATEMENT

This facsimile transmission may contain information that is privileged and confidential and is intended only for the use of the person or entity named above. If you are neither the intended recipient nor the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use or distribution of this information is strictly prohibited. In addition, there are federal civil and criminal penalties for the misuse or inappropriate disclosure of confidential patient information. If you have received the transmission in error, please notify contact person immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.

VERIFICATION OF TRANSMISSION OF PHI

Please contact _____ at _____ to verify receipt of this Fax or to report problems with the transmission.

I verify the receiver of this Fax has confirmed its transmission:

Name: _____ Date: _____ Time: _____

DMH Treatment Team Representative

DEPARTMENT OF MENTAL HEALTH

ACCOUNT TRACKING SHEET

NOTE: Consult with County Counsel prior to making any non-routine disclosures.

(See Accounting of Disclosure of PHI 2.4.1)

Date of Disclosure	Name and Address Of Entity Receiving PHI	Description of PHI Disclosed	Statement of Purpose of Disclosure
	Eli Lilly P.O. BOX 231000 CENTREVILLE, VA 20120	Current Medication Financial Information	Patient Assistance Program - Zyprexa
	Janssen Pharmaceutica P.O. BOX 222098 Charlotte, NC 28222-2098	Current Medication Financial Information	Patient Assistance Program-Risperdal
	Pfizer, Inc. P.O. BOX 52119 Phoenix, AZ 85072	Current Medication Financial Information	Patient Assistance Program-Geodon

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____ **MIS#:** _____

Facility/Practitioner: _____

Los Angeles County – Department of Mental Health

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client/Previous Names	Birth Date	MIS Number
Street Address	City, State, Zip	

AUTHORIZES:

Name of Agency

Street Address

City, State, Zip Code

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Assessment/Evaluation
___ Laboratory Results
___ Entire Record (Justify)
_✘_ Other (Specify): PATIENT ASSISTANCE PROGRAM APPLICATION

___ Results of Psychological Tests
_✘_ Medication History/ Current Medications

___ Diagnosis
___ Treatment

PURPOSE OF DISCLOSURE: (Check applicable categories)

___ Client's Request
___ Other (Specify):

Will the agency receive any benefits for the disclosure of this information? ___ Yes _✘_ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/_____/_____
Month Day Year

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

_____ _____
Contact person Agency Name

_____ _____
Street Address City, State, Zip

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Signature of Client / Personal Representative Date

If signed by other than the client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: _____/_____/_____
Month Day Year